Iowa Department of Inspections and Appeals
Assisted Living Program
AMENDED Final Complaint Investigation Report

Assisted Living Program: **Complaint Intake #: 15920**

Tim Hendricks, Director of Housing Operations
Oak Park Place
1381 Oak Park Place
Dubuque, IA 52002-2286

Date of Investigation:

February 27, 2008

Monitor(s):

Stephanie Cummins, SW MA

Definitions:

The following definitions are relevant:

Regulatory Insufficiency - A violation of a statutory or rule provision within the Iowa Code or Iowa Administrative Code (IAC) governing assisted living programs. A regulatory insufficiency requires a plan of correction to be presented to, and approved by, the Department of Inspections and Appeals (DIA).

Plan of Correction - A written response to one or more regulatory insufficiencies that are rule violations [321 IAC 26.2(5)(a)]. The plan should identify how, and by a specific date, an insufficiency will be corrected. The plan is due to DIA within ten (10) working days of the program's receipt of a Complaint Investigation Report. Depending on the circumstances, DIA may revisit the assisted living program to confirm progress in fulfilling a plan's corrective measures.

Dementia-specific assisted living program - An assisted living program certified under 321 IAC - chapter 25 that either serves five or more tenants with dementia or cognitive disorder staged between 4 and 7 on the Global Deterioration Scale or holds itself out as providing special care for persons with cognitive disorder or dementia, such as Alzheimer's disease, in a dedicated setting.

Overview:

A complaint investigation on-site visit was conducted at Oak Park Place on February 27, 2008. In preparing this report, the following information was considered:

Current Program Census:

General Population Program (GPP)* **–** A program that is not a Dementia Specific program, but may have tenants with cognitive disorder.

Current number of tenants without cognitive disorder:	40
Current number of tenants with cognitive disorder:	2
Total Population:	**42**

Dementia Specific Program (DSP)* **–** A program that is a Dementia Specific Program by definition or holds itself out as providing specialized care in a dedicated setting but may have tenants without cognitive disorder.

Current number of tenants in a DSP that holds itself out as providing specialized care in a dedicated setting:	14
Current number of tenants without cognitive disorder:	2
Total Population:	**16**

***These are the census numbers represented by the program to be applicable at the time of the on-site.**

Accreditation Status – Not applicable.

Program History – There were Regulatory Insufficiencies this certification period in the areas of: Evaluation of Tenants, Criteria for Exclusion of Tenants, Service Plans, Nurse Review, Food Service and Staffing.

Complaint Investigation – The complaint investigator(s) made the observations detailed in the following areas.

A. Staffing - The provisions of this section address the program's staffing and training practices and associated documentation in responding to the identified needs of the tenant. [321 IAC 25.33]

Complaint Allegation: The following information and allegations were self reported by the program. On 1-20-08, Staff #1 struck Tenant #1 on the tenant's right arm. This event was witnessed by Staff #2, who stated Staff #1 tried to get Tenant #1 to take his/her medication and sit down. Tenant #1 struck Staff #1 and then Staff #1 struck the tenant. The tenant did not have any injuries. Staff stated that on 1-21-08, Staff #1 told Tenant #2 to sit down and shut up and also yelled at Tenant #3. The tenants resided in the dementia unit and Staff #1 was terminated.

Monitoring Observation:

Staff #1 had mandatory dependent adult abuse training completed on 4-19-06 and had six hours of dementia training on 8-8-07 and 8-9-07. The program provided a document that indicated Staff #1 was on the nurse aide registry. Staff #1 was terminated on 1-24-08.

The Director of Housing Operations provided an investigation summary of events regarding the incidents with Staff #1. Staff #2 reported to administrative staff that she witnessed Staff #1 strike Tenant #1. After this was reported, the Director of Housing Operations, Director of Nursing (DON) and the supervisor met with Staff #1 on 1-21-08. Staff #1 stated she never hit a tenant and she knew staff could not hit tenants. Staff #1 wanted to face her accuser and stated if they wanted to get rid of her, just say so and she would walk out. Staff #1 was told by the Director of Housing Operations that she was being sent home until the investigation was complete. Staff #1 refused to sign the disciplinary form and Staff #1 left at 10:15 a.m. The DON assessed Tenant #1 and found no marks or bruises. The DON and supervisor spoke separately with other staff, asking them if they had noticed any kind of abuse in the program. Staff #4 stated she witnessed Staff #1 telling Tenant #2 to sit down and shut up on 1-21-08. Staff #3 stated Staff #1 yelled at Tenant #3 to "stop fooling around, what's your problem today" on 1-21-08. Staff #1 was informed by phone, on 1-24-08, she was terminated from her position and a report had been made to the state and they would decide whether an on-site investigation was necessary.

Staff #2 provided a statement to the program and was interviewed. Staff #2 indicated on 1-20-08 at approximately 11:00 a.m. she heard Staff #1 yell at Tenant #1. Staff #1 yelled at Tenant #1 to take his/her medications and to sit down. Staff #2 stated Staff #1 had her left hand on Tenant #1's right arm. Tenant #1 hit Staff #1 and then Staff #1 hit Tenant #1 on his/her right arm. Tenant #1 then hit Staff #1 back. Staff #1 walked away and Staff #2 walked over to Tenant #1 and asked if she was okay. Tenant #1 responded yes. Staff #2 did not say anything to Staff #1 the rest of day and reported the incident to the DON on Monday, the next day. The DON told Staff #2 she should have reported it immediately and she would have taken care of it. Staff #2 stated she did not report it the day it occurred because she was afraid of Staff #1. According to Staff #2, the DON redirected her on how and when to report abuse.

Staff #4 provided a statement to the program. Staff #4 witnessed Staff #1 telling Tenant #3 to sit down and shut up. Staff #4 stated she was not sure what led up to this being said and stated Staff #1 was asked what was going on and did not answer.

Staff #3 provided a statement to the program. The statement was dated 1-21-08 and stated Staff #3 observed Staff #1 yelling at Tenant #3 to "stop fooling around, what's your problem today." Staff #1 was trying to get Tenant #3 to take his/her medications.

Staff #2, Staff #3 and Staff #4 had mandatory dependent adult abuse. Staff #2, Staff #3 and Staff #4 had documented mandatory dependent adult abuse training. According to a program document dated 2-14-08, there was staff meeting and mandatory dependent adult abuse training was one of the topics listed. Staff #2 and Staff #3 were in attendance at the meeting.

Staff #2, Staff #3 and Staff #4 stated staffing was sufficient to meet the needs of the tenants. The staffing pattern in the dementia unit, on 1-20-08, the day of the alleged incident, was two direct care staff, including Staff #1 and Staff #2. The staffing pattern in the general population area on 1-20-08 was three direct care staff, including a float. The staffing pattern currently in the dementia unit is three direct care staff on first and second shifts and two on third shift.

The Director of Housing Operations indicated the police were not called. The Department of Human Services (DHS) was called and did not investigate. The program self reported the issue to DIA. The Director of Housing Operations indicated families of Tenant #1, #2 and #3 were notified of the alleged incidents.

- Regulatory Insufficiency: The program did not consistently provide sufficient trained staff at all times to fully meet the tenants' identified needs. (25.33 (1))

- Regulatory Insufficiency: The program did not establish and maintain a safe and homelike environment for individuals of all income levels who require assistance to live independently but who not require health-related care on a continuous twenty-four hour per day basis (231C.1 (2)a).

Dated this 23rd day of April, 2008.